



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-17-3106-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

June 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$198.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was issued in the amount of \$1272.42 on 3/31/2017. We have reviewed the charges and determined that reimbursement was correct."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2017	72100	\$198.76	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
 - Z710 – The charge for this procedure exceeds the fee schedule allowance
 - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

- MOPS – Services reduced to the outpatient perspective payment system
- MSIN – This is a packaged item. Services or procedures included in the APC rate, but not paid separately
- 193 – The charge for this procedure exceeds the fee schedule allowance
- W3 – The charge for this procedure exceeds the fee schedule
- X598 – Claim has been re-evaluated based on additional documentation submitted; No additional payment due

Issues

1. What is the applicable rule that applies to reimbursement?

Findings

1. The requestor is seeking \$198.76 for outpatient procedure rendered on February 17, 2017.

The insurance carrier denied disputed services with claim adjustment reason code MSIN– “This is a packaged item. Services or procedures included in the APC rate, but not paid separately.”

The Division Rule that applies to Outpatient Hospital Services is found at 28 Texas Administrative Code §134.403. Section 134.403 (b) (3) and (d) states in pertinent part,

(b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare

and

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

The Medicare Claims Processing Manual 100-04, Chapter 4, 10.1.1 - Payment Status Indicators, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> defines the following:

An OPPTS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPTS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPTS or under another payment system or fee schedule.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPTS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPTS Addendum B.

Review of the applicable Medicare Payment Policy finds Procedure Code 72100 has status indicator Q1, which has the following definition:

(1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S,” “T,” or “V.”

(2) Composite APC payment if billed with specific combinations of services based on OPPTS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.

(3) In other circumstances, payment is made through a separate APC payment.

Per Addendum B found at www.cms.hhs.gov procedure code 99285 is assigned to APC 5025. Per Addendum A at referenced CMS website, APC 5025 has a Status Indicator of “V.” Based on the Medicare payment policy procedure code 72100, Status Indicator “Q1” is packaged into procedure code 99285 Status Indicator “V.”

The Division finds the applicable Medicare payment policy packages the service in dispute. No separate reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	July 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.